

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33902

State File No.

Registrar's No.

4325

Registration District No.

Primary Registration District No.

149

1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Northeast Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 60 Days
In this community 30 Years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME MABEL CLAIRE PATTEN

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Fe. 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Wm. T. Patten, Sr. 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased June 27, 1893
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 3 11 hr. min.

9. Birthplace Wichita Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Homemaker
None

11. Industry or business

12. Name James A. Sheehan

13. Birthplace Pa.
(City, town, or county) (State or foreign country)

14. Maiden name Eliza Corns

15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant William T. Patten, Sr.

(b) Address 433 Norton

17. (a) Burial (b) Date thereof 10-11-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director C. H. Blackman & Son, Inc.

(b) Address Kansas City, Mo.

19. (a) 10-11-43 (b) H. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 433 Norton
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 8
year 1943 hour 3 minute 15 P.M.

21. I hereby certify that I attended the deceased from July 15, 1942 to October 8, 1943
that I last saw her alive on October 8, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Liver 2 yrs

Due to Chronic Dysentery
Due to Diabetes + Arteriosclerosis

Other conditions None 46 f
(Include pregnancy within 3 months of death)

Major findings: None
Of operations

Of autopsy None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury

23. Signatures D. Frank & Co. (M. D. or other) Do
Address 4316 E 7th St. K. Mo. Date signed 10-11-43

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

H. D. Blackman

Licensed Embalmer No.....

3639

P. O. Address.....

17 C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.